

The Department of Vermont Health Access Medical Policy

Subject: Prosthetics and Orthotics

Last Review: March 21, 2017*

Revision 3: April 11, 2016

Revision 2: January 2, 2015

Revision 1: January 10, 2014

Original Effective: June 10, 2013

***Please note: Most current content changes will be highlighted in yellow.**

Description of Service or Procedure

Per Medicaid Rule 7508, “a prosthetic device is a replacement, corrective or supportive device to: 1) artificially replace a missing portion of the body; 2) prevent or correct physical deformity or malfunction; or 3) support a weak or deformed portion of the body. Prosthetics include orthotics.”

Prefabricated devices are manufactured in a quantity without a specific patient in mind. They may be modified for use by a specific beneficiary (“custom fitted”). *A device assembled from prefabricated parts is considered prefabricated.*

Prefabricated off the shelf devices are those which require “minimal self-adjustment” at the time of fitting by the beneficiary, caretaker for the beneficiary, or supplier. This minimal self-adjustment does not require the services of a certified orthotist or an individual who has specialized training. For example, adjustment of straps and closures, bending or trimming for final fit or comfort (not all-inclusive) fall into this category. (LCA A52457, 2015)

Prefabricated custom-fitted devices are “Items requiring substantial modification by a qualified practitioner.” (LCA A52457, 2015)

Custom devices are manufactured to fit a specific patient and require a prescription. The device is fabricated from basic materials and involves *substantial modification* to customize it to the specific patient. It may include some prefabricated components. (LCA A5247, 2015).

Disclaimer

Coverage is limited to that outlined in Medicaid Rule that pertains to the member’s aid category. Prior Authorization (PA) is only valid if the member is eligible for the applicable item or service on the date of service.



Medicaid Rule

[7102.2](#) Prior Authorization Determination

[7103](#) Medical Necessity

[7508](#) Prosthetic Devices

Medicaid Rules can be found at <http://humanservices.vermont.gov/on-line-rules>

Coverage Position

Prosthetics/orthotics may be covered for members:

- When the device is prescribed by a licensed medical provider, enrolled in the Vermont Medicaid program, operating within their scope of practice in accordance with the Vermont State Practice Act, who is knowledgeable in the use of prosthetics/orthotics, and who provides medical care to the member AND
- When the clinical guidelines below are met.

Coverage Guidelines

The prosthetic/orthotic may be covered for members who:

- Have a medical condition that results in the need for a prosthetic/orthotic to:
 1. artificially replace a missing portion of the body;
 2. prevent or correct physical deformity or malfunction; or
 3. support a weak or deformed portion of the body.
- **For custom devices only:** The device must be properly evaluated by a qualified professional practitioner with specialized skills in the evaluation of prosthetics/orthotics. Depending on the nature of the device, this practitioner may be a physical therapist, occupational therapist, physician, physician assistant, or nurse practitioner. Fitting of the device must be performed by one of the above listed professionals or by a supplying provider who has been certified to ensure that the prescription is properly fulfilled.

Clinical guidelines for repeat service or procedure

Medicaid expects that beneficiaries will care for their prosthetics/orthotics properly so that the device will be usable for at least the duration recommended by the manufacturer. Most prefabricated devices have a reasonable useful lifetime of at least 1-3 years. Custom devices are expected to have a reasonable useful lifetime of at least 3 years. Prior authorization is required if an excess quantity is required.

Coverage for replacement equipment will be provided only when the existing device or system no longer effectively addresses the beneficiary's needs. A police report is required for items that are lost, stolen, or irreparably damaged in an accident. Devices will be covered for repair if the repair price is less than 50% of the replacement price.

Per Medicaid Rule 7508.3:

- Coverage of Medicaid-approved shoes is limited to two pairs per adult beneficiary per calendar year unless a prior authorization review finds special circumstances that warrant additional pairs.

Type of service or procedure covered

Per Medicaid Rule 7508.2, “items and services that have been pre-approved for coverage are limited to:

- Artificial limbs;
- Artificial larynx;
- Breast forms [limited to post-mastectomy];
- Prosthetic shoes;
- Ostomy products;
- Parenteral and enteral nutrition services;
- Prosthetic eyes;
- Braces and trusses for the purpose of supporting a weak or malformed body member;
- Orthotic shoes as an integral part of a leg brace or affixed to an integral part of a leg brace;
- Aircast splints;
- Shoe lifts, elevation heels, wedges; and
- Molded orthopedic shoes when prescribed for diabetes, severe rheumatoid arthritis, ischemic, intractable ulceration, congenital defects, and deformities due to injuries.

The complete policies regarding hearing, visual, vocal, and dental prostheses are contained elsewhere in Medicaid rule.

Custom items are covered only when prefabricated devices cannot meet the medical need. Medicaid rule 7102.2 requires that the least expensive, medically appropriate item be supplied. Therefore, in situations where a prefabricated device is available, the ordering and dispensing of a custom device requires physician documentation that demonstrates the medical need for a custom device.

Regardless of whether prior authorization is required or not, a completed medical necessity form **that is current for the billed date of service**, must be available in the provider’s files for legal and auditing purposes.

Per Medicaid Rule 7508.3:

- Prosthetic devices must be prescribed by a physician or podiatrist who is enrolled with Vermont Medicaid.
- Devices must be appropriate for the beneficiary’s age, gross and fine motor skills, developmental status, mental functioning, and physical condition.
- Payment will be made for **one** primary piece of medical equipment.
- Custom made arch supports prescribed by a physician or podiatrist are covered when they meet the definition of an orthotic.

Per Medicaid Rule 7603.3:

- For individuals not covered by Medicare residing in a nursing facility, Medicaid covers prosthetic devices and leg, arm, back and neck braces.

Type of service or procedure not covered (this list may not be all inclusive)

Per Medicaid Rule 7508.3:

- Duplicate items are not covered (e.g., two pairs of customized orthotics)
- Duplicate services/equipment in multiple locations will not be covered.

Per Medicaid Rule 7508.5:

- Orthopedic shoes when prescribed for flat feet are not covered;
- Orthotics/prosthetics that primarily serve to address social, recreational, or other factors and do not directly address a medical need are not covered.

Per Medicaid Rule 7508.7:

- Prosthetic/orthotic suppliers may not bill Medicaid for items furnished by hospitals to their inpatient or outpatients. Hospitals cannot bill separately for prosthetic or orthotic supplies.
- Modifications made within 60 days of purchase are not covered because they are considered part of the initial reimbursement.

Certain accessories/components cannot be covered in addition to the base code, because:

- They are considered part of the base device;
- They are considered not reasonable and necessary;
- They are incompatible with the base code.

Examples of this include, but are not limited to, the following table related to knee orthotics (Local Coverage Article A46762, 2014):

Base Code- prefabricated devices:	Additional codes: not separately payable due to: considered part of the base code, not reasonable and necessary, or incompatible with the base code.
K0901	K0672, L2275, L2390, L2405, L2425, L2430, L2492, L2750, L2780, L2785, L2810, L2820, L2830, L4002
K0902	K0672, L2275, L2390, L2405, L2415, L2425, L2492, L2430, L2750, L2780, L2785, L2810, L2820, L2830, L4002
L1810	L2390, L2397, L2750, L2780, L4002
L1812	L2390, L2397, L2750, L2780, L4002
L1820	L2390, L2397, L2750, L2780, L2810, L4002
L1830	K0672, L2397, L4002
L1831	K0672, L2390, L2397, L2425, L2430, L2750, L2780, L2795, L2810, L2820, L2830, L4002
L1832	K0672, L2390, L2405, L2415, L2425, L2492, L2430, L2750, L2780, L2785, L2820, L2830, L4002
L1833	K0672, L2390, L2405, L2415, L2425, L2430, L2492, L2750, L2780, L2785, L2820, L2830, L4002
L1836	K0672, L2397, L2750, L2780, L2810, L2820, L2830, L4002
L1843	K0672, L2275, L2390, L2405, L2425, L2492, L2430, L2750, L2780, L2785, L2810, L2820, L2830, L4002
L1845	K0672, L2275, L2390, L2405, L2415, L2425, L2492, L2430, L2750, L2780, L2785, L2810, L2820, L2830, L4002
L1847	K0672, L2390, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1848	K0672, L2390, L2397, L2425, L2430, L2750, L2780, L2795, L2810, L2820, L2830, L4002

L1850	K0672, L2275, L2750, L2780, L2810, L2820, L2830, L4002
Base code- custom devices:	Additional codes:
L1834	K0672, L2397, L2800, L2820, L2830, L4002
L1840	K0672, L2275, L2320, L2330, L2750, L2780, L2800, L2810, L2820, L2830, L4002
L1844	K0672, L2275, L2320, L2330, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1846	K0672, L2275, L2320, L2330, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1860	K0672, L2397, L2820, L2830, L4002

All additional codes that are not in the above table that describe components that cannot be physically incorporated into the device or which are incompatible with the base orthosis are also not covered.

Providers found to have billed for the noncovered codes are subject to recoupment.

Additional Information

It is a DVHA expectation that the providers will provide education to the beneficiary on the following:

- Care and use of the device; AND
 - Appropriate skin/body part care related to the device use; AND
 - Appropriate wear schedule; AND
 - Customer support for any problem with the device, throughout the life of the device.
- Documentation of this education must be kept in the provider record.

Prior Authorization:

All generic “xx99” codes and non-specific codes require prior authorization.

Certain other codes also require prior authorization. Consult the fee schedule available on the Vermont Medicaid website at <http://dvha.vermont.gov/for-providers/health-services>

Special Information re: foot orthotics

L3000: Devices billed with this code must demonstrate the intent of the UCB type orthosis, which is to provide a very high level of control for the rearfoot via high medial, lateral, and posterior walls made of rigid plastic. Providers must document the medical need for this significant level of rearfoot control and have the documentation available for legal and auditing purposes in provider’s patient records.

L3010: Devices billed with this code must demonstrate the need for longitudinal arch support.

L3020: Devices billed with this code must demonstrate the need for both longitudinal and metatarsal arch support.

Special Information - external breast prostheses: A breast prosthesis is only covered for a patient who has had a mastectomy.

Special information - lower extremity prosthetics: “A determination of the medical necessity for certain components/additions to the prosthesis is based on the beneficiary’s

potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to:

1. The beneficiary's past history (including prior prosthetic use if applicable); and
2. The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and
3. The beneficiary's desire to ambulate.

Clinical assessments of beneficiary rehabilitation potential must be based on the following classification levels:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator. Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator. Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete." (LCD L33787 2015)

Contraindications/Precautions:

Improperly fitted or inadequate devices may do more harm than good. It is vital that devices be appropriately assessed and reassessed, and properly constructed, to provide the appropriate level of support, proper fit, and function.

Overly aggressive devices may also do more harm than good. Orthotics may weaken a body part that may be capable of becoming stronger with proper exercise and alignment as determined by a physician/physician extender or physical/occupational therapist.

It is Medicaid's expectation that the provider who delivers the device to the patient is fully certified and that the provider has witnessed and documented that the device is properly fitted to the beneficiary, that the device provides the appropriate level of support, and that it is functioning properly. This documentation must be available in the beneficiary's medical records for auditing purposes.

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